UW Medicine
PRIMARY CARE

Welcome To Medicare

Name _____ Birthdate_____

Please fill out the following questionnaire. It will allow the provider to focus on your main concerns during the visit, and allow more time for discussion.

REVIEW OF NUTRITION / EXERCISE:

	Yes	**No**
Do you eat a well balanced diet, including protein, high fiber, fruits and vegetables?	( )	( )
Do you exercise regularly?	( )	( )

Type of exercise _____
Frequency _____

ACTIVITIES OF DAILY LIVING:

In your present state of health how much difficulty do you have with the following activities? Please rate your level of impairment:

0 = None 1= Mild 2=Moderate 3=severe 4=complete

Preparing food and eating:	0	1	2	3	4
Bathing yourself:	0	1	2	3	4
Getting dressed:	0	1	2	3	4
Using the toilet:	0	1	2	3	4
Moving around from place to place:	0	1	2	3	4

	Yes	**No**
In the past year have you fallen or had a near fall?	( )	( )
Do you feel safe in your home environment?	( )	( )
Do you find yourself having trouble hearing people speak?	( )	( )
Do you wear a hearing aid/device?	( )	( )
Do you have a fire extinguisher in your home?	( )	( )
Do you have a smoke detector?	( )	( )

DEPRESSION:

Over the past two weeks, have you felt down, depressed or hopeless?	( )	( )
Over the past two weeks, have you felt little interest or pleasure in doing things?	( )	( )

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CARDIAC RISK FACTORS:

Smoker:	( )	( )
Obesity:	( )	( )
Diabetic:	( )	( )
Known heart disease:	( )	( )
Family history of heart disease:	( )	( )
Sedentary lifestyle:	( )	( )
Hyperlipidemia (High Cholesterol):	( )	( )

SCREENING AND PREVENTIVE SERVICES:

Have you had any of the following?

Pneumococcal vaccine:	Date _____
Influenza vaccine:	Date _____
Hepatitis B vaccine:	Date _____
Screening mammography (women only):	Date _____
Screening pap smear and pelvic exam (women only):	Date _____
Colorectal cancer screening (Colonoscopy or Hemocult Card):	Date _____
Screening for diabetes (Glucose or Blood Sugar testing):	Date _____
Diabetes self management training:	Date _____
Bone densitometry screening:	Date _____
Screening for glaucoma:	Date _____
Nutrition Counseling:	Date _____
Cardiovascular screening blood tests (Cholesterol)	Date _____
End-of-Life planning:	Date _____

Would you care to discuss any of the following with your provider?	**Yes**	**No**
Diabetes self management training:	( )	( )
Nutrition counseling:	( )	( )
End-of-life planning:		
Living Will:	( )	( )
Durable Power of Attorney for Medical Affairs	( )	( )